Attach 1

NHS
Wandsworth
Clinical Commissioning Group

Notes of a meeting of the Board held on 11th September 2013

Present:	Nicola Jones (NJ)	CCG Lead (Chair)
	Graham Mackenzie (GM)	Chief Officer
	Hardev Virdee (HV)	Chief Financial Officer
	Stephen Hickey (SH)	Lay Member Governance
	Jeremy Ambache (JA)	Lay Member Patient and Public Involvement
	Andrew Neil (AN)	Secondary Care Doctor
	Di Caulfeild-Stoker (DCS)	Registered Nurse
	Peter Ilves (PI)	West Wandsworth Locality Commissioning Group Lead
	Rod Ewen (RE)	Battersea Locality Commissioning Group Lead
	Mike Lane (ML)	Joint Wandle Locality Commissioning Group Lead
	Seth Rankin (SR)	Joint Wandle Locality Commissioning Group Lead
	Lucie Waters (LW)	Director of Commissioning and Planning
	James Olweny (JO)	Director of Corporate Affairs, Performance and Quality
	Andrew McMylor (AM)	Director of Delivery and Development
	Tom Coffey (TC)	Board Advisor
	Houda Al-Sharifi (HAS)	Director of Public Health
	Dawn Warwick (DW)	Director Wandsworth Adult Social Services

In attendance:

Sandra Allingham (SA)	(Minutes)

13/096	**Welcome and Introductions** NJ welcomed all attendees to the meeting.	
13/097	**Declarations of Interest** None reported.	
13/098	**Minutes of the previous meeting held on 10th July 2013** The Minutes were agreed as being an accurate record.	
13/099	**Matters Arising** 13/086 Mental Health – GM reported that the request to make the Minutes of the CRG meetings available had been discussed at Management Team and with Healthwatch, and it was intended that approved Minutes would be made publicly available. A standard format for Minutes was currently being developed to be used for meeting Minutes. 13/089 Procurement Plan – GM confirmed with the Board that the Procurement Plan discussed at the previous meeting had been formally approved following discussion in Part II. 13/090 Wandsworth CCG Assurance Framework – JO confirmed that the points raised at the previous meeting would be discussed with NHS England (NHSE) at a meeting scheduled for the following week and further information will be discussed at Management Team.	
13/100	**Chair's Actions** Two Actions were reported in the Executive Report later in the Agenda.	

13/101	**Cardio Vascular Disease** NJ, as Clinical Lead for Cardio Vascular Disease (CVD), and Michelle Heller, Service Redesign Manager, presented the report from the CVD Clinical Reference Group (CRG). Stephen Hickey assumed the role of Chair for this item. The report highlighted that CVD was the highest cause of mortality within Wandsworth, involving a wide range of conditions. The report identified: • areas of work that had been undertaken over the past year, particularly around heart failure, cardiac rehabilitation, and peripheral arterial disease, • future plans, • Recent Lifetimes Event focusing on CVD prevention, raising awareness and promoting services in the community. The work of the CRG was directed by the National Service Framework but this had recently been superseded by the Cardiovascular Outcomes Strategy – it was intended that the work-plan of the CRG would be mapped against that strategy. Comments and questions were noted from the members of the Board: • Differential Commissioning – how would issues linked to higher needs in certain areas be addressed going forward? HAS confirmed the support to target identified needs appropriately – work had been done to provide an understanding of the need and this would now be linked with the level of activity currently provided. There was some discussion around the recent publicity regarding NHS Health Checks, but it was noted that there was evidence that conditions were being identified earlier and the intervention was therefore more effective. NJ stated that the NHS Health Checks programme was now in year-five of a five year programme so this was the most challenging year yet, but that Wandsworth had an excellent track record in the programme and it was anticipated that the targets would be met for the current year. NJ asked Locality Leads to encourage practices within their respective Localities to engage in the programme and actively promote and offer checks. • Input from Public Health and community care partners was key to this work. • Obesity was acknowledged as a contributing factor to CVD, what impact do the weight management programmes have? NJ stated that prevention was now within the Public Health domain therefore input from the Local Authority (LA) was important - there was a long history of working together and these services were not seen as separate, but the commissioning of weight management services was now done through Public Health. There was a structured weight management service in Wandsworth, however, referrals into the service were not as high as they could be. Issues around communications and marketing were looking to be addressed. • Weight Management Programmes – It was noted that a re-tender exercise was undertaken last year, with a review of all services to be provided in a range of settings to focus on the whole family. A number of outcome measures were identified against which the services were monitored. Health Checks were a key way to manage referrals into the services. • Need to consider young people as well as prevalence. • Referrals from secondary care – NJ confirmed that the CRG had been working closely with the heart failure team with a number of audits undertaken. The level of referrals from secondary care was improving, and an audit was being done to look at admissions. • Commissioning Intentions 2014/15 – Would any additional or different areas be commissioned for next year? NJ stated that heart failure would remain one of the priority areas for next year.	**PI/RE/ ML/SR**

- Would there be any targeted work for discrete user groups? NJ reported that work had been done with PH to identify the right areas of focus on clinical pathways, deprived areas etc, with a range of approaches being used.
- Would the Stroke sub-group deal with suspected TIA and TIA prevention? Services for suspected TIA were in place already. The prevention programmes would apply to all cardiovascular conditions as they share common risk factors.

Comments and questions were invited from members of the public:

Kate Swinburn, PPI Reference Group:

- Would the recommendations from the Stroke national strategy be implemented locally? NJ responded that the CVD CRG did not report on stroke work, however, there was a sub-group which would map their work against the strategy. A lot of work was being done on the Stroke strategy and with the SGH Stroke Unit.
- Was reference made within records of people that suffer from Aphasia? NJ stated that there had been a gap regarding Aphasia – this information was now being documented in the discharge record but this had not yet been audited.
- Was there any engagement with community groups and charities for these conditions to make use of work currently being done by them? NJ confirmed that the aim of the Lifetimes Event was to involve third sector organisations and groups. The write-up of the event would be used to feed back the messages from the event.

Sarah Rackham:

- As part of the work with the charitable and community sectors, there was a need for more social prescribing, particularly physical activity, as part of the well-being model. PI stated that the Self Management Programme had been developed, and the Care For Me website allowed groups and organisations to self-register providing more visibility.

Sue Elliott:

- There was no mention of alcoholism as a contributing factor to CVD.

Malik Gull:

- Work was being done by the Behavioural Unit linking in to a new piece of research on how to get community groups to develop social prescribing.

Vicky Diamond:

- Putney High Street was the worst polluted street in Wandsworth – was any work being done with Transport for London on this? HAS reported that Wandsworth Council was taking this issue very seriously with a number of hybrid buses being used, and working with businesses to look at delivery times.

In summary, SH noted the strong welcome to the work of the group, particularly around the importance, wide ranging scope, and impacts for patients. The main themes from the discussion were summarised:

- Issues regarding focused targeting, particularly high risk geographic areas, practices, and conditions, to identify opportunities and need.
- Locality Leads to look at local data to identify where further work would need to be done, particularly around referrals into follow-up services, inclusion of voluntary sector and community organisations, and to make sure that GPs and acute services understand these routes.
- Commissioning Intentions 14/15 round – a short term piece of work to identify

	the priorities for next year. NJ assumed the role of Chair.	

13/102	**West Wandsworth Locality Clinical Group Annual Report**
	PI presented the report for the West Wandsworth Locality Clinical Group. The report highlighted the work undertaken against the agreed priorities, particularly around the following areas:
	
	• Engagement – Good engagement with Locality practices, Patient Consultative Groups, Seldom Heard Group, Practice Managers, Roehampton University, Roehampton Forum, Roehampton Partnership, and Carers.
	• Mental Health (Children services) - Placement of third party organisations to deliver services from general practice.
	• Mental Health (Adult services) – Close working with the Council to develop services.
	• Family Action – This was now in the second phase.
	• Sexual Health – A primary care based service will be launched with local schools, with GPs being matched to schools.
	• CVD – A pilot for cholesterol testing had been implemented.
	• Obesity
	• Smoking
	• Cancer Diagnosis
	
	Comments and questions were noted from members of the Board:
	
	• What difference was being made to practices from these activities? PI stated that engagement created a two-way conversation between practices and the CCG and provided information and support for decision making.
	• What role do Localities play in the Reference Groups? Each locality has a GP in each clinical reference group so the information flow and discussions in localities inform clinical leads in each CRG.
	• How can improvement for patients be measured from the activities undertaken? PI confirmed that the action log identified multiple targets to be achieved, and the next stage would be to look at data regarding outcomes.
	• How can practices with established active Patient Groups support those practices that do not have active Patient Groups? PI stated that there would be some joint visits to practices involving Locality Managers, Clinical Leads and patient representatives.
	• Was there a commissioning strategy to deal with the under-use of the Queen Mary's Hospital (QMH) site? LW confirmed that there were three areas of work running in parallel regarding QMH:
	  ○ Review of estates both in QMH and across Wandsworth
	  ○ Strategy for QMH in a wider context and how this could link in to BSBV
	  ○ Patient and GP needs in Roehampton.
	
	Comments and questions were invited from members of the public:
	
	• The issue around active Patient Groups was not specific to West Wandsworth, however, there were many ways to capture the patient voice not just through Patient Groups.
	• Caution was expressed that the plans for GPs to be linked to schools could raise some governance issues and GPs would need to receive some training in order to be aware of potential issues.
	
	Following on from the discussion, NJ summarised the main themes identified:	

	• the report highlighted a high level of engagement undertaken in the Locality; • there was a need to understand practice performance on a Locality basis; • further work was still be done around active patient participation; and • issues around QMH to be clarified and work was ongoing regarding this.	
13/103	**Board Assurance Framework** JO tabled an amended front sheet and first page of the document to reflect a change to Risk 29 as the principal risk relating to Better Services Better Value – the risk relating to Out of Hospital Strategy was a control to the Better Services Better Value risk and some further work was required to define both of those. The Board Assurance Framework (BAF) was the main process for the Board to receive assurance on the principal risks. The format for the BAF had been in development over the past few months with work done to identify the principal risks to delivering the Corporate Objectives. The BAF had been reviewed by Management Team and Integrated Governance Committee (IGC). The document provided a breakdown of the risks against each of the Corporate Objectives. GM commented that, from the discussions at IGC, there was a high level of assurance that the risks were appropriate, acknowledging that this was not a fixed document and would always be subject to change. The development of the BAF had also been supported by the Internal Audit process thus providing additional assurance. Comments and questions on the BAF were noted: • Better Services Better Value (BSBV - risk 29) – Was there a further risk that the programme might not be taken forward and capacity to cope with emergency admissions? JO acknowledged that there were two parts to BSBV – initial implementation of the programme in 2013/14, and achievement of ambitions. It was agreed that the capacity concerns should be reflected. • It was noted that the BSBV programme related principally to hospitals in South West London, and that the Out of Hospital Strategy related to all of the BSBV issues that apply across London – the BSBV risk would impact differently on each of the Localities. • Where were issues and risks regarding new structure arrangements and working with the Council addressed? LW confirmed that this was included within risk 50 – Failure to commission services in a way that delivers integrated and sustainable models of care. • Was engagement with patient partners and remote memberships captured? AM confirmed that there were additional operational risks regarding Corporate Social Responsibility and Member Engagement. The Board approved the content of the Board Assurance Framework. GM thanked JO and SA for the work done to develop the BAF.	

13/104	**Human Resources** AM presented the following papers. <u>Staff Charter</u> The idea for the Staff Charter had been launched at the previous Staff Away Day, following which a Working Group was set up to develop the proposal and feed	

	back to teams. The Staff Charter identified the rights and responsibilities of both individuals and the organisation to support staff members, based around five key areas which linked in to the Vision and Values of the CCG. GM welcomed the document noting that there were some process issues to be confirmed. It was expected that the Staff Charter would be signed by individuals as part of the induction process and to be revisited as part of the appraisal process. An informal process would probably need to be developed to handle any challenges. Comments and questions were noted: • This linked with previous discussions regarding dedicated time for staff to develop innovation and to participate in schemes within the community to grow understanding and experience of Wandsworth as part of developing the CCG's Corporate Social Responsibility. • Does the Staff Charter promote a no blame culture and how would this be reflected in Trust policies? AM confirmed that a range of Human Resources policies were being reviewed and would reflect this. • Strong focus on leadership, training and development should be included as part of career development. AM stated that this was included as part of the training and appraisal process. • Important that this remained a live document and could be used as a checklist on a regular basis. • It was be useful for roles such as GP Clinical Leads, CRG Leads and Pathway Leads to also be aware of this as well. • Need to make sure that both the Management Team and Board members also follow this model and identify how this was being done. • Could a rewards and incentives approach be used to instil this throughout the organisation? AM agreed to take this forward. The Board endorsed the style and process for the Staff Charter. <u>Staff Appraisal Process</u> The paper provided a summary of all the documents relating to the proposed process. The proposed process would provide a consistent approach to include a mid-year review and regular formal meetings with line managers. The moderation of appraisals and objectives would enable a common understanding on which challenges on the level and realism of objectives could be made. Management Team would review objectives to ensure they were realistic. Comments and questions on the proposed process were noted: • Did the proposed arrangements align with Agenda for Change? AM stated that the Agenda for Change process was flexible and would also be subject to change – there would always be a need for an effective appraisal process. • How would the ratings be utilised? AM stated that these would be used to ensure the appraisal and objective setting process was followed consistently. • Paperwork should be easy to use, clearly demonstrate objectives, and link to other processes. • Were there sufficient resources to provide 360^{o} feedback for staff? AM stated that the CCG was working with the Commissioning Support Unit (CSU) to provide a tool for people to use. It was noted that an Equality Impact Assessment had not yet been completed for	**AM** **AM**

	both the Staff Charter and the Staff Appraisal Process. The Board approved the Staff Appraisal Process. <u>Training Brochure</u> The statutory and mandatory training brochure was current in development, which would provide a comprehensive training approach. It was acknowledged that this would remain a live document, providing appropriate training and other opportunities for staff. Comments and questions on the Training Brochure were noted: • Wandsworth Council undertook a lot of the training outlined and opportunities should be explored on how some of this could be done together. AM would take this forward. • Monitoring of the policy should reflect effectiveness of training as well as numbers. • Would there be sufficient time for staff to undertake the required training? AM stated that there were different timescales for different aspects of training, and that there was a requirement for training to be implemented. The CCG would work to explore the best way to provide this. The Board noted the content and approved the direction of travel. DW left the meeting.	
13/105	**Executive Report** NJ noted an amendment to the information on the Chair's Action relating to the Diagnostics Procurement, in that the recommended procurement route for MRI and Ultrasound would be through the Any Qualified Provider process. The content of the report was noted.	
13/106	**Finance Report** HV presented the report noting the following key messages: • Currently on track to deliver financial target; • Continuing issues regarding validation of acute hospital activity data due to changes in legislation; • Impact on the transfer of Specialised Commissioning to NHSE had not yet been clarified – guidance previously published assumed that this would be cost-neutral, therefore, it was assumed that there should be no financial impact for the CCG. Legal advice obtained stated that NHSE was able to transfer resources as an acceptable approach but the financial situation of individual CCGs should be taken into consideration; • An acceleration of costs had been reported at Month 4 in both acute and Continuing Care – this will be discussed in detail at the next Finance Resources Committee meeting. The overall financial position was reported as moving closer to the worst case scenario, if: • the continued increase in Continuing Care, • the validation exercise does not provide a significant positive outcome, and • the investment funding was fully utilised.	

	It was expected that the position would change, but the CCG should still be able to achieve the financial target with contingencies in place to maximise all resources. Comments and questions on the report were noted: • Mitigating Controls and Actions regarding increased allocation – HV confirmed that a level of funding had already been transferred and work was currently being done to ascertain if the amount transferred was accurate. It was expected to have the definitive position at the end of September, however, the latest indication was that this would not be a significant amount for Wandsworth. The potential risk had been reduced from the previous month and contingencies were in place to cover the current level of risk. • Financial Ledger System – SH confirmed that this had been raised as an issue at the previous Board meeting and asked whether a response had been received from NHSE regarding this. HV stated that this had been raised at a national level and more work was being done around the flexibility of the system. NHSE were still looking at the issues but it was unlikely that the system would change in this financial year. • Data Challenges – HV reported that this remained a risk for all commissioners, include NHSE, but some work-around solutions had been put in place for Personal Identifiable Data. The level of Wandsworth challenges was now increasing but was not yet at previous levels. NHSE had stated that a solution should be identified by the end of October and would look to change legislation next year. There was an additional risk regarding planning for 2014/15 as this would be based on 2013/14 activity. The content of the report was noted.	
13/107	**Performance Report** The report set out the current position. Comments and questions on the report were noted: • CVD – mortality rate and preventable mortality rates – it was noted that this included a number of elements and would be followed-up outside of the meeting. • HAI Root Cause Analysis – It was noted that there was a significant downward trend for MRSA incidents (down from 300 in previous years), with a target of zero incidents. All incidents were unacceptable and subject to Root Cause Analysis. • C.Diff – This reflected the year-to-date position. The content of the report was noted.	
13/108	**Handling Requests for Information** A process had been developed setting out a consistent approach with identified timescales for responding to requests for information in line with good customer care standards. It was suggested that a reasonableness test should be included, in a similar way to the Freedom of Information process. It was agreed that this would be included.	
13/109	**Approved Minutes** The content of the Minutes were noted. DCS noted that a CCG Pressure Ulcer Review Group was being set up, which would involve joint working with SGH.	

13/110	**Open Space** No questions were noted.	
13/111	**Any Other Business** None. There being no further business the meeting closed at 12:25.	
Date of next meeting: 9th October 2013		

Signed: .....

Date: .....

ACTIONS

Ref No.	Item	Lead	Timescale
13/101	Cardio Vascular Disease – Locality Leads to encourage practices within their respective localities that were not currently delivering the NHS Health Checks target.	PI/RE/ ML/RE	
13/104	Staff Charter – Comments to be taken forward. Equality Impact Assessment to be completed for both Staff Charter and Staff Appraisal Process.	AM AM	